Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Indian Health Services
And
Tribal Mental Health Services

Billing Instructions

February 1999

About this publication

This publication supersedes all previous MAA Indian Health Services Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
February 1999

Received too many billing instructions?
Too few?
Address Incorrect?

Please detach, fill out and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

How do I become a DSHS provider?

Call the Provider Enrollment Unit according to the first letter of your business name:

A-H	**(360) 664-0300**
I-O	**(360) 753-4712**
P-Z	**(360) 753-4711**

Where do I send hardcopy claims?

Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Where do I call if I have questions on…?

Mental Health?

Mental Health Division
(360) 902-0787
or
(360) 902-0845

Indian Health?

American Indians/Alaska Natives Liasion
(360) 753-1431

Where do I call if I have questions on…?

Payments, denials, general processing questions?

Provider Relations Unit
1-800-562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
1-800-562-6136

Electronic Billing?

(360) 753-0318
or write to:
Electronic Billing
PO Box 45564
Olympia, WA 98504-5564

How can I obtain other copies of billing instructions or numbered memoranda?

Check out our website at:
http://www.wa.gov/dshs/maa/
or
Write to:
Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562

Definitions

This section contains definitions, abbreviations, and acronyms used in these billing instructions which relate to the Medical Assistance Program.

Client – An applicant for, or recipient of, DSHS medical care programs.

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program. (WAC 388-87-007)

Department or DSHS - The state Department of Social and Health Services.

Encounter – A face-to-face contact between a health care professional and an Indian Health Services (IHS) beneficiary eligible for Medicaid, for the provision of Title XIX defined services through an IHS or Tribal 638 facility within a 24-hour period ending at midnight, as documented in the patient's record.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Fraud - An attempt to obtain benefits or payments in a greater amount than that to which a provider is entitled by means of:

(a) A willful false statement
(b) Willful misrepresentation, or by concealment of any material facts; or
(c) A fraudulent scheme or device, including, but not limited to:

  (i) Billing for services, drugs, supplies, or equipment that were unfurnished, of lower quality, or a substitution or misrepresentation of items billed; or
  (ii) Repeated billing for purportedly covered items, which were not in fact covered.

Healthy Options – See Managed Care.

Indian Health Services (IHS) - A federal agency under the Department of Health and Human Services and contracted tribal health programs entrusted with the responsibility to assist eligible American Indians and Alaska Natives with health care services.

Internal Control Number (ICN) – A 17-digit claim number appearing on the MAA Remittance and Status Report near the client's name that is used as a means of identifying the claim.

Managed Care – A comprehensive system

of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With, or assigned to, a primary care provider;
- With, or assigned to, a plan; or
- With an independent provider who is responsible for arranging or delivering all contracted medical care. (WAC 388-528-001)

Maximum Allowable - The maximum dollar amount MAA will reimburse to a provider for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to:

a) Categorically needy [CNP] as defined in WAC 388-503-0310 and 388-503-1105; or
b) Medically needy [MNP] as defined in WAC 388-503-0320.

Medical Assistance Administration (MAA) - The administration within the Department of Social and Health Services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) cards – The forms the Department of Social and Health Services uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

a) 'Part A' covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
b) 'Part B' is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client and which consists of:

a) First and middle initials (or a dash (-) if the middle initial is not available).
b) Six-digit birthdate, consisting of numerals only (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Primary Care Case Manager (PCCM) - A physician, Advanced Registered Nurse Practitioner, or Physician Assistant who provides, manages, and coordinates medical care for an enrollee. The PCCM is reimbursed fee-for-service for medical services provided to clients as well as a small monthly management fee.

Program Support, Division of (DPS) - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Provider or Provider of Service - An institution, agency, or person:

- Having a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department.

Remittance and Status Report - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client.

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Tribal Mental Health Services – A qualified tribal mental health program which contracts with the Department of Social and Health Services under the provisions of the December 1996 Memorandum of Agreement between the federal Health Care Financing Administration and Indian Health Services.

Usual & Customary Fee – This is the rate that the provider generally charges non-Medicaid customers. This is the maximum rate that may be billed to the department for a certain service or equipment.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

"638" Contract – A contract between tribes and Indian Health Services that states tribes will assume responsibility for providing health care for all their members. Authorized by Public Law 93-638, the Indian Self Determination Act, as amended, U.S. Code, § 450 et seq.

General Billing Information

What is the time limit for billing?

State law requires that you present your final bill to the Medical Assistance Administration (MAA) for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill MAA within 365 days after you provide a service(s). Delivery of a service or product does not guarantee payment.

- **For clients who are <u>not</u> eligible at the time of service, but are later found to be eligible:** Bill MAA within 365 days from the Retroactive[1] or Delayed[2] certification period.

- **MAA will not pay if:**

  - ✓ The service or product is not medically necessary;
  - ✓ The service or product is not covered by MAA;
  - ✓ The client has third party coverage, and the third party pays as much as, or more than, MAA allows for the service or product; or
  - ✓ MAA is not billed within the time limit indicated above.

[1] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

[2] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be Medicaid-eligible, and then bill MAA for those services.

Fees

Bill MAA your usual and customary fee (what you charge the general public).
MAA's payment will be the lower of the billed charges, or MAA's maximum allowable rate, and is payment in full.

Third-Party Liability

Although the billing time limit for MAA is 365 days, an insurance carrier's time limit for claim submissions may be different. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must bill the insurance carrier(s) indicated on the client's Medical Assistance IDentification (MAID) card. Even if you haven't received notification of action by the insurance carrier, MAA's 365-day billing time limit must be met. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA.
- Attach the insurance carrier's statement.
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the *Comments* field of the Electronic Media Claim (EMC).

The list of third-party carrier codes is in the General Information Booklet, or you may call the Coordination of Benefits Section at 1-800-562-6136 if you have further questions.

What records does MAA require me to keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide. **Chart** means a summary of medical records on an individual patient. **Record** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service must be in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records must be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include but not be limited to the following:

1. Date(s) of service.
2. Patient's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.

Charts/records must be available to DSHS or its contractor and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.] (WAC 388-501-0130)

Indian Health Services

About the program

It is the goal of the Medical Assistance Administration (MAA), in cooperation with Indian Health Services, to raise the health status of American Indians to the highest possible level.

Indian Health Services acts as the principal federal advocate for Indian people by assuring that they have access to all health programs that they are entitled to as United States citizens.

Enrollment Options

American Indians/Alaska Natives have the options of:

- Enrolling with a Healthy Options care plan;
- Enrolling with a Primary Care Case Manager (PCCM); or
- Remaining fee-for-service.

Who is eligible to obtain services from Indian Health Services?

American Indian/Alaska Native clients with one of the following identifiers on their Medical Assistance IDentification (MAID) cards **are eligible** to receive services from Indian Health Services:

- **CNP** (Categorically Needy Program)
- **CNP-QMB** (Categorically Needy Program - Qualified Medicare Beneficiary)
- **LCP-MNP** (Limited Casualty Program – Medically Needy Program)
- **MNP-QMB** (Medically Needy Program – Qualified Medicare Beneficiary)

Who is not eligible to obtain services from Indian Health Services?

American Indian/Alaska Native clients with one of the following identifiers on their MAID cards **are not eligible** to receive services from Indian Health Services:

- **Children's Health**
- **Family Planning Only**
- **GAU - No out-of-state care** (General Assistance Unemployable)
- **Emergency Hospital & Ambulance Only** (Medically Indigent Program)
- **QMB – Medicare Only** (Qualified Medicare Beneficiary)
- **W – No out of state care**

Provider Requirements

To become a provider with MAA, you must first be an Indian Health Services (IHS) facility or a Tribal Medical facility.

To find out what the specific requirements are to become an IHS facility, contact the:

Indian Health Services
Portland Area Office
503-326-2023, 503-326-7277,
503-326-3288, or 503-326-7273

☛**Note**: A tribally-contracted Indian Health facility may elect to participate as a Federally Qualified Health Center (FQHC) rather than becoming an Indian Health provider. As an FQHC, you would be subject to FQHC billing requirements. For information call: (360) 586-3745.

What is covered?

- MAA will cover one medical encounter per client, per day.

  Exception: If, due to an emergency, the same client returns on the same day for a second visit with a different diagnosis, a second encounter is allowed.

  Example: *If a client comes in for diabetes and hypertension, it is considered one medical encounter, regardless of how many providers the client sees in the course of the visit. However, if the client leaves, slips on the ice and returns for emergency care, that is a second diagnostic episode and a second encounter may be billed. As always, documentation must be present for all encounters.*

- MAA will cover one dental encounter per client, per day (regardless of how many procedures are done or how many providers are seen).

  Exception: If, due to an emergency, the same client returns on the same day for a second visit and has a different diagnosis, a second encounter is allowed.

  Example: *If a client comes in for a routine cleaning and x-rays, it is considered one dental encounter, regardless of how many providers the client sees in the course of the visit. However, if the client leaves, chips a tooth, and returns for emergency care, that is a second diagnostic episode and a second encounter may be billed. As always, documentation must be present for all encounters.*

How do I bill?

- Complete a HCFA-1500 claim form. (See *How to Complete the HCFA-1500 Claim Form* and attached samples.)

- Use state-assigned encounter code **5999M – Indian Health Clinic Encounter** in field 24D on the HCFA-1500 claim form (see example). This encounter code is an all-inclusive code for Medicaid eligible services.

Tribal Mental Health Services

About the program

In Washington State, Medicaid eligible individuals generally receive mental health services through providers that contract with Regional Support Networks.

Through a Memorandum of Agreement (MOA) between Indian Health Services and the federal Health Care Financing Administration, Medicaid-eligible American Indians/Alaska Natives may elect to receive mental health services through Tribal Mental Health programs.

Who is eligible?

Clients with one of the following identifiers on their Medical Assistance IDentification (MAID) cards **are eligible** to receive mental health services from Tribal Mental Health programs:

- **CNP** (Categorically Needy Program)
- **CNP-QMB** (Categorically Needy Program - Qualified Medicare Beneficiary)
- **LCP-MNP** (Limited Casualty Program – Medically Needy Program)
- **MNP-QMB** (Medically Needy Program – Qualified Medicare Beneficiary)

Who is not eligible?

Clients with one of the following identifiers on their MAID cards **are not eligible** to receive mental health services from Tribal Mental Health programs:

- **Children's Health**
- **GAU - No out-of-state care** (General Assistance Unemployable)
- **Emergency Hospital & Ambulance Only** (Medically Indigent Program)
- **Family Planning Only**
- **QMB-Medicare Only** (Qualified Medicare Beneficiary)
- **W – No out-of-state care**

Provider Requirements

To become a provider with MAA and the Mental Health Division, you must:

- Meet the requirements of the December 1996 Memorandum of Agreement between the Health Care Financing Administration (HCFA) and Indian Health Services (IHS); and
- Have a contract with the Mental Health Division.

Providers may do so by exercising one of the following options:

- Be licensed by the Mental Health Division;
- Maintain a "638" contract with Indian Health Services for mental health services;
- Maintain a contract with DSHS that specifies the Tribal Mental Health certification standards will be met; or
- Maintain private accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

Tribes will need to submit information to the Mental Health Division when they begin their contract and when there are changes in enrollment status of those they serve. Contact Yvonne Misiaszek at (360) 902-0787 or Gloria Pierce at (360) 902-0845 of the Mental Health Division.

What is covered?

- MAA will cover one mental health professional encounter per client, per day.

  Exception: If, due to an emergency, the same client returns on the same day for a second visit and has a different diagnosis, a second encounter is allowed.

  Example: *If a client comes in for psychotropic medication management, it is considered one mental health professional encounter, regardless of how many providers the client sees in the course of the visit. However, if the client leaves, becomes suicidal and returns for emergency care, that is a second diagnostic episode and a second mental health professional encounter may be billed. As always, documentation must be present for all encounters.*

How do I bill?

- Complete a HCFA-1500 claim form. (See *How to Complete the HCFA-1500 Claim Form* and attached samples.)

- Use state-assigned encounter code **5988M – Tribal Mental Health Encounter** in field 24D on the HCFA-1500 claim form. This encounter code is specifically for mental health services.

- Tribes should refer to the ICD-9-CM Manual for diagnostic codes, usually the 300 series, having to do with mental illness.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (fields 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- Center all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

Field/Description

1a. **Insured's I.D. No.**: Required. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card consisting of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d) An alpha or numeric character (tiebreaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager name. This field must be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number of Referring Physician**: When applicable, enter the seven-digit, MAA-assigned identification number of the provider who referred or ordered the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved for Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC*. If the client is one of twins or triplets, enter the **B** and indicate the client on the claim as "twin A or B" or triplet "A, B, or C" as appropriate.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the claim number listed on the Remittance and Status Report.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K).**

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., February 04, 1999 = 020499).

24B. **Place of Service**: Required. Use the following code for Washington State Medicaid:

Code Number	To Be Used For
3	Indian Health Center, clinic, or Tribal Mental Health facility

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate state-assigned procedure code as follows:

5988M	Tribal Mental Health Services
5999M	Indian Health Services

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed Do not include dollar signs or decimals in this field.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance Explanation of Benefits (EOB). If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the Name, Address, and Phone # on all claim forms.

PIN#: Please enter your seven-digit provider number assigned to you by MAA.